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EDITORIAL

Many students and a number of the staff have enquired as to the fate of the Questionnaire. As is well known within the Hospital the forms were distributed, year by year, early in December and the return was not sufficient to be of statistical use until early January. It was perhaps unfortunate that the project should have been launched so near to the end of the pre-clinical term since inevitably some of these students evaded at first the net and in consequence had to be contacted in the January thereby delaying the analysis.

The total return from the medical college was 85% or nearly 400 completed forms. Of these only one had been answered in a ridiculous manner which is in itself a sufficient comment or the responsible and adult interest that was generally felt towards this enquiry. There were only 2 students both in the first pre-clinical year who absolutely refused to have anything to do with the questionnaire and this is probably a reflection of their maturity of outlook. The missing 15% were felt to be those whose forms were mislaid either on the way out or the way back or those whose natural lethargy prevented any unnecessary activity particularly with Christmas so near.

With the return of an adequate number of forms the *Journal* sub-committee divided up into three splinter groups, one member qualified and left the hospital, another concerned himself with the problem of financing the analysis and report and the third per-

formed a preliminary analysis. This preliminary survey was only of the written comments "Best taught subject; Worse taught subject, etc.", which would have been time consuming and very expensive had they been done by the statistician. The results of these opinions were also co-related to the years so that their value could be further assessed.

The activities of the fund-finding member are at last bursting into fruition and several drug-houses are subscribing to the cost of analysis which is in itself not inconsiderable. The problem of financing any more complex analysis is yet to be faced.

The questionnaire forms are at the moment being analysed by a firm of statisticians and their original survey will be available for publication shortly. It is proposed that the questionnaire results should be published in parts each dealing with a different view of the student's life, i.e., their ambitions, their environment, etc. Also should the *Journal* be able to raise sufficient funds it is hoped to publish the complete survey as a booklet which may not only act as a mirror to the soul of Bart's but enhance the reputation of the Hospital throughout the country breaking down the traditional conservatism and revealing a dynamic, vital, and exciting insight into the future Bart's men. No longer will the other London hospitals be able to say of our Hospital's sons "Super-knowledgable, super-confident, and supercilious" for they will know us for what we are.

Gilbert and Sullivan Society

On March 9th, 1958, the Gilbert and Sullivan Society gave their second performance since their foundation some eighteen months ago. 'Patience' was this year's choice and the success of the evening proved how well-founded this was, since the hall was packed with representatives from all the hospital estates; four rows being occupied exclusively by consultants and their friends which was twice the number reserved at the 'Gondoliers' last year.

The outstanding performance of the evening was universally held to be that of the conductor Brian Richards who, apart from the actual performance, had devoted much valuable time and energy to bullying of a recalcitrant chorus at the rehearsals. He, with the soloists, gave a splendid showing of what Bart's in general and they in particular can do. The narrator for this year was Dr. Lehmann, who provided a delightful and amusing continuo leading the audience gently through an exciting land, decorated with dainty groups of lovelorn maids and aesthetic poets.

For the next performance it is proposed to unite with the Rahere Choir to perform a more serious work at the end of this year and then to present a further comic-opera in the early months of next year.

Wessey Rahere Club

The Spring Dinner of the above Club will take place at the White Hart Hotel, Salisbury, on Saturday, 19th April, 1958.

Mr. John Beattie will, it is hoped, be present as Guest of Honour.

Membership of the Club is open to all Bart's graduates practising in the West Country. Further details will be circulated to members.

At the special request of many members in the Eastern Wessex, the Club is meeting at Salisbury so that Bart's graduates in the Winchester, Portsmouth, Bournemouth area may take part.

Any Bart's graduates within striking dis-

tance will be welcome to dine and are asked to write to the Honorary Secretary:—

Mr. A. Daunt Bateman,
11, The Circus,
Bath, Somerset.

Atmosphere cleared?

Mr. R. E. Waller has pointed out that his article entitled "Smog" in the February *Journal* should have carried the title "Researches on Atmospheric Pollution in London." An apology is offered to Mr. Waller for any misunderstanding that may have arisen as a result of this mistake.

ANNOUNCEMENTS

Engagement

KNIGHT-LAWTON.—The engagement is announced between Surg. Lieut. Robert John Knight and Gillian Mary Frances Lawton.

Marriage

GABRIEL - RATCLIFFE.—On March 22nd, Dr. David Wilson Gabriel to Dr. Diana Ratcliffe.

CAIRNS - BANWELL.—On March 27th, 1958, at St. Timothy's Church, Ridley Blvd., Toronto. John David Cairns to Dorothy Mary Banwell.

Births

BUCKLEY.—On February 25th, to Elizabeth, wife of Dr. Anthony R. Buckley, a son.

EVANS.—On February 4th, to Muriel, wife of Robert J. Evans, M.D., a son, Miles Liddiard.

PERFECT.—On March 2nd, at Awali, Bahrain, to Joan, wife of Dr. John Perfect, a daughter (Elizabeth Verdon).

RICE.—On March 15th, to Brita, wife of Dr. Noel Rice, a son (Andrew Sven).

TURNER.—On March 3rd, to Patricia, wife of Dr. John Turner, a daughter (Angela Helen), a sister for Susan and Penelope.

VICKERY.—On February 26th, to Betty, wife of Dr. C. M. Vickery, a daughter.

Deaths

BRADLEY.—On March 22nd, Edwin John Bradley, M.D., F.R.C.S.(Ed.), aged 67. Qualified 1913.

GRIFFITH.—On March 21st, Dr. Herbert Stuart Griffith. Qualified 1915.

LOWRY.—On March 2nd, Dr. Ernest Ward Lowry, aged 87. Qualified 1907.

VENN.—On March 15th, Dr. John Archibald Venn, aged 74. Elected a Perpetual Student June, 1940.

WILSON.—On February 22nd, Harry Theodore Minden Wilson, D.S.O., Lieut. Col., R.A.M.C. (retired). Qualified 1904.

WINCE.—On March 13th, Dr. Walter George Wince, aged 79. Qualified 1903.

WOOD.—On February 22nd, Dr. Maurice Dale Wood, aged 82. Qualified 1898.

New Addresses

Dr. J. D. Cairns

Office: 1516 Bayview Avenue, York Mills, Toronto, Ontario.

Residence: Apt. 222, 200 Ridley Blvd., Toronto, Ontario.

Dr. W. W. Wells to 12 Sydney Place, Bath.

University of London

Dr. Charles F. Harris has been elected vice-chancellor of London University for the year 1958-59.

MEDICAL STAFF

The following appointments to the medical staff take effect from the dates mentioned:—

Skin Department

Registrar—Miss A. I. Scott, 1.4.58.

Eye Department

Registrar—Mr. M. S. Wilson.

Department of Pathology

Registrar—Miss J. Cook, 1.4.58.

Surgical Professorial Unit

Research Assistant—

Mr. Peter Courtenay, 1.4.58.

Mr. Hosford's Firm

Junior Registrar—

Mr. S. G. Thompson, 1.5.58.

Medical Unit

Junior Registrar—

Mr. R. Crampton, 1.9.58.

Children's Department

Senior Registrar (Chief Assistant)—

Dr. Seymour Mason, June, 1958.
(Replacing Dr. Hugh-Jones for one year, while he is in America).

CALENDAR

Sat. May 3	Dr. A. W. Spence on duty. Mr. C. Naunton Morgan on duty. Mr. R. A. Bowen on duty. Cricket: v. U.C.H. (A). Tennis: v. Westminster (H).
Sat. „ 10	Dr. R. Bodley Scott on duty. Mr. R. S. Corbett on duty. Mr. R. W. Ballantine on duty. Cricket: v. R.A.M.C. Crookham (H). Tennis: v. Charing Cross and Royal Dental Hospitals (A).
Sat. „ 17	Dr. E. R. Cullinan on duty. Mr. J. P. Hosford on duty. Mr. C. Langton Hewer on duty. Cricket: v. Balliol College (A).
Sat. „ 24	Medical and Surgical Units on duty. Mr. G. H. Ellis on duty. Cricket: v. Queen's College, Cambridge (H).
Sat. „ 31	Dr. Geoffrey Bourne on duty. Mr. J. B. Hume on duty. Mr. F. T. Evans on duty. Tennis: v. St. Mary's (H).

CANCER AND MEDICAL EDUCATION

by MALCOLM DONALDSON

Everybody agrees that a good general education is essential in order to produce a good doctor, and I have always admired and envied the 'classical man' although I have never been able to make up my mind whether classics makes the good brain better, or whether the good brains are attracted to the classics. Of one thing I am quite certain, that a classical education is worse than useless to an average or subnormal brain, and there must be some better way to train such brains than putting a boy in front of a Latin or Greek grammar for hours on end and construing 10 lines of Latin prose per day. It would have been better training if we had been set to work out jigsaw puzzles.

Coming now to the pre-clinical course I have no doubt that this has improved since my time as a student. The 1st M.B. consisted of a smattering of Zoology, Botany, Chemistry and Physics. These were taught without any reference to medicine which made the last two very boring, but in later years I would have given a great deal to have had a real knowledge concerning biochemistry and physics.

The 2nd M.B. was Anatomy and Physiology, but even these were not really associated with medicine. The one clinical note mentioned in Cunningham's Anatomy was that an abnormal deep circumflex artery sometimes occurred, and might be cut during an operation for hernia. One of my teachers said it occurs once in 7,000 cases, the chance of this person getting hernia is another 1 in 7,000 and if it is cut it is clamped and tied. The fact that I remember it after fifty years shows how important it is for anatomy to be taught in its relation to surgery and medicine. Perhaps it is in these days. There is a story that in the ancient days a physician advised students to forget their physiology as soon as they entered the wards. In my day no encouragement was needed to forget.

Statistics was another subject much neglected in my time. The idea that "Statistics can prove anything" should be replaced by the idea that "nothing can be proved without statistics."

At this point a word must be said about research. My late colleague Herbert Williamson used to say "Medicine without research is like a body without a soul." In my time there were a number of research scholarships offered, but usually the candidates put in a programme that would take more than a life time to carry out, instead of the year allotted. Some people say researchers, like poets are born and not made, but every poet has to learn to read and write, and therefore it seems reasonable that a person who has a scholarship should be given a set task and it should be seen that he carries this limited task out under supervision.

A research mind is simply an inquisitive mind, and without this no one can be a good doctor. When in S. Africa recently I was struck by the amount of encouragement given to the students in the Johannesburg Medical School to carry out bits of research.

Coming now to the Clinical stage of Medical Education I will start by quoting from a book by Charles Newman "Evolution of Medical Education in the 19th Century" in which he asks "What is the aim of Medical Education?" It would appear that in 1800 the opinion prevailed that "it was to produce a cultured and highly educated gentleman", and nothing else mattered. Then in the latter part of the nineteenth century "technology began to supplant wisdom to the gradual eclipse of the patient." That danger I believe exists even in these days.

To quote again from Newman, "The Medical Profession is failing and for a long time has failed to provide something which the public wants: something the public will have whatever the cost, something that at the present time is supplied by quacks and the smooth West-end doctors. They want to feel that the doctors feel for them." The

other day I received a letter from an old lady, a friend of mine, aged 83 who had noticed that in a letter to the press I had used the expression "Family Doctors". She wrote "these are now as extinct as the Dodo and have been replaced by 'expert plumbers'." I answered that I agreed with her to some extent but if there was a choice between an 'expert plumber' and a 'Father Confessor' I would prefer the plumber, but I believe the two can and should be combined.

There are people who deplore the growth of specialization and "the learning of more and more about less and less", but we cannot put the clock back, and indeed which of us would not prefer to be treated by a person who sees diseases like our own every day of his or her life rather than one per year.

The word "specialist" is often used in contra distinction to the Family Doctor sometimes spoken of as the G.P. I think that is quite wrong. General Practice is a Speciality and the most difficult of all specialities to practice, and perhaps the most important, in my time there was no special training for this speciality. It may be asked how can I speak about general practice as I have never experienced it except to act as an unqualified dispenser when I was an impecunious student, which is of course illegal. On the day I qualified I did a locum in the same practice in the Edgware Road for three or four weeks. Luckily the first patient to whom I was called, a Dutchman, diagnosed himself, said he had Malaria, would I give him some quinine. Since I retired, however, I have been giving a great many lectures to the public, and from time to time after these lectures a member of the audience has come to me and complained about their doctor. Of course one does not believe all they say, and one tries to be loyal to the profession, but there is no doubt that there is some truth in their complaints. I believe that many doctors are so busy that they have no time to understand the minds of their patients, and this of course is particularly true in regard to Cancer.

The time is past when the doctor in the village was the 'High Priest', when anything he said was considered absolute truth, and no questions asked. Some doctors still believe that to ask for a second opinion is an insult to them.

It is indeed tragic that a doctor should lose the confidence of his patients, even if this only

happens occasionally, but I suggest it is his own fault. Some patients are not fools, and when they ask intelligent questions expect intelligent answers in simple lay language. Of course talking to patients is a bore when the waiting room is full of people, but it is a very important part of the doctor's work "to suffer fools gladly".

What then is the answer to Newman's question 're the aim of Medical Education'? Surely the answer is that we must accept the fact that it is an age of 'Specialization' and that General Practice is a speciality, and students must be trained for all these specialities.

There will be a general pre-specialist training common to all, but in my opinion it should not be so detailed as it is at present. The time for great detail comes after the compulsory Pre-registration hospital appointment by which time the student will know what speciality he or she intends to take up.

I am not in a position to suggest a detailed schedule for such a training, but it may be hoped that the College of General Practitioners is busy drawing up a syllabus for this purpose. Here it is only possible to suggest a few points, e.g. that a period of apprenticeship in a general practice, at present voluntary, should be compulsory, and take place after the Pre-registration Appointment and before the appointment as a House Physician. That they should attend a course in nursing. Of course nursing is a separate skilled profession, but sometimes there is no nurse, who then is there to make the patient comfortable? A nurse knows the elements of medicine and the doctor should be taught the elements of nursing. In the training of the Family Doctor great stress should be laid on Psychology (not Psychiatry) because as already mentioned many doctors do not understand their patients.

As far as students are concerned they probably see a sufficient number of cancer cases, but perhaps too little emphasis is laid on "early stage" diagnosis. The description and illustrations in the textbooks in my time were all concerning advanced cases, and the only possible treatment to judge by these books was to order the undertaker.

This perhaps explains the terrible fatalistic attitude adopted by the profession outside the hospitals. The Family Doctor hardly ever sees an "early stage" case, which of

course makes it nice and easy for diagnosis. Often the patient, after being sent to the hospital for palliative treatment, returns to end his days under the care of the G.P. These cases of advanced cancer are perhaps the most difficult type of case to look after in the whole of medicine, and students have no opportunity to learn, because teaching hospitals cannot be filled with dying patients. Some doctors tell the relatives that they can do nothing more, and abandon the case. The patient is then taken to a "quack" and if the tumour is a slow growing one the quack makes a reputation and his fortune.

The apathy of the majority of Family Doctors concerning cancer is appalling. Any attempt to get a discussion in the local branch of the B.M.A. is answered by, "the doctors are not interested and will not attend", and this in a disease which is responsible for about one in every five deaths from all causes.

What then is the remedy for this terrible state of affairs? It has been suggested that patients should go direct to a Cancer Detection Centre, and thus to 'by pass' the Family Doctor. This is done in U.S.A. and in theory is excellent, but in practice it is impossible. At the New York Centre there is a waiting list of over a year. In Canada the idea has been given up, not only because of the expense in finding one unsuspected case of cancer but because such a centre demands the services of many experts and their time is largely wasted which is more important than waste of money.

There is no doubt that the responsibility for the 'Preliminary Diagnosis of Cancer' must be left with the Family Doctor, and the Final diagnosis and treatment will be in the hands of a Team of experts in the hospital.

If this is to be carried out there must be a very great change in the attitude of the Medical Profession towards Cancer, the Family Doctor must be much better trained for the Preliminary diagnosis and given much better facilities, so that he can take smears etc. to send to the Pathologists.

Practitioners seldom see "early stage" cases of cancer because the patient delays on the average six months after noticing a suspicious symptom, and many wait for more than a year, before going to the doctor. The reason for this can be summed up in three

words *fear and ignorance*, which can only be overcome by education.

In 1953 the Ministry of Health wrote to 146 Local Health Authorities urging them to start Cancer education schemes for the public, so far only about 17 are doing anything at all, the excuse being that the family doctors in the area are against it.

Cancer is surrounded by a psychological atmosphere that exists in no other disease. I call it 'Cancer Smog'. It is probably true that there are very few cases of true 'Cancer-phobia', and by that I mean patients who are so worried that it interferes with their normal life. It is true that each year there are a few unfortunate people who commit suicide because they suffer from an obsession that they are afflicted with cancer. True 'Cancer-phobia' needs a psychiatrist for treatment.

On the other hand it is an undoubted fact that nearly 100 per cent. of the population suffer from 'Cancer Apprehension' to a greater or less extent. This apprehension can be divided into two types (A) Personal Apprehension, and (B) Impersonal Apprehension. In the first type the patient may notice some symptom such as slight pain for which there is no obvious reason, and they think "Can this be Cancer?" A good example of this occurs frequently in women when they get a little discomfort or pain in the breast, which is often connected with menstruation. It is impossible to say how common is this type of 'Personal Apprehension' because the patient is too nervous to talk about it. If they go to the doctor, they do not mention the real cause of their visit, and if they are not told that it is not cancer they return again and again being diagnosed as Neurasthenics, when they are really 'Cancer Apprehensives'. I used to see a great many such cases in out-patients, and after examining them it was my custom to say, "I am glad to say that there is nothing serious and *no evidence of cancer*." On a great many occasions the patient says "Thank God, that is what I really came about".

The second type, 'Impersonal Apprehension', is very common and consists of Fear that if a person talks about or even mentions the word cancer, the other person will be frightened. Very often the speaker himself will have no fear of the disease. Why people should think that other people are different

to themselves is difficult to understand. I have often demonstrated this 'Impersonal Apprehension' by asking a lecture audience if they would prefer to be told the truth if they suffered from cancer. Nearly 100 per cent. will hold up their hands. If this question is followed by asking "If a friend or relation of yours had cancer, do you think they should be told?" very few hold up their hands. Another example is that members of the 'Cancer Information Association' just started in Oxford are seldom willing to send on pamphlets to their friends "lest their handwriting should be recognised", but they will send me a list of their friends with addresses to whom pamphlets should be sent provided I do not mention their own name.

Unfortunately many doctors, who, of course, do not suffer from 'Personal Apprehension', suffer from 'Impersonal Apprehension' and refuse to discuss cancer with lay people. This keeps up the terrible "Hush, hush" and conspiracy of silence about the disease and deters patients from consulting their doctors. Those who are brave enough to mention the word often get laughed at by their doctor and never mention it again, but go on worrying. I have on several occasions been told, "It is all very well to tell us to go to the doctor, but I could not go to a doctor about Cancer. I hate being laughed at".

There is another thing that prevents people going to a doctor—the feeling that they are being cowardly. Some of you may have experienced this feeling. I certainly did ten years ago, but it did not prevent me seeking advice. And that gave rise to another piece of evidence in connection with the 'Psychology of Cancer'. The day before going into hospital I said to a senior member of the B.E.C.C., "I shall not be able to attend your committee tomorrow because I am going in to be investigated for Carcinoma of the Stomach". To this he replied, "Well, you must know that you have not got it or you would never go in". When I came out after an exploratory laparotomy, which I am glad to say proved that the condition was due to old T.B. adhesions, a colleague said, "Of course, you were the only one who thought it was malignant". In any other disease would anybody have made these remarks? Whilst lying in bed during my investigation I tried to analyse my own feelings, but found it im-

possible, because I believed that there was not sufficient evidence in favour of malignancy. That may have been a protective mechanism. Fortunately I was never able to experience the effect of being told that I had cancer, but several books have been written on the subject, such as "I Live with Cancer" and "Determined to Live".

This brings up the point—should a doctor tell a patient that he or she is suffering from Cancer? At present the principle nearly always adopted is to tell the relatives everything, but to keep the truth from the patient.

Although it is not possible to be dogmatic on the subject I believe that as a principle this is wrong for the following reasons.

- (1) It is extremely doubtful whether it is possible to deceive a patient for more than a short time. The patient will often pretend to be deceived in order to comfort their own relatives and the doctor.
- (2) I believe the majority of patients prefer to know the worst.
- (3) That when the patient realises the truth he or she believes that the doctor made a mistake and "did not diagnose it in time".
- (4) That if years after a relative thinks he has cancer it is difficult to convince him otherwise because he knows the doctor deceived (or tried to) his relative.
- (5) Because patients are never told the truth the public never hears about the cures, but only about the fatal cases. This leads to the idea that it is useless to go to the doctor as cancer cannot be cured.
- (6) It keeps up the terrible "Hush, hush" and conspiracy of silence.

In 1953 the British Empire Cancer Campaign sent a questionnaire to all General Practitioners in the country, about 20,000, asking if they approved of Cancer Education of the Public. They were only allowed to say yes or no. Of these only 24% answered, and of these 2,148 voted in favour and 2,683 against, a majority against of 435. Since 76% did not answer, statistically these figures are of little value.

The majority of the medical profession who oppose cancer education of the public do so on the grounds that talking about cancer will increase apprehension. Those of us who have been working on this subject know that this is NOT true. In the last few years I have given over 500 lectures to the public, 69 already this year. There is plenty of evidence against this argument. In Manchester 1,200 women were interviewed and asked if they considered more information about cancer should be given to the public—76.0% replied YES, 9.0% said NO, and 15.0% were doubtful.

When I was working in Yorkshire, after each lecture the following printed voting papers were distributed.

"Some people have suggested that lectures such as you have just heard do no good, and indeed may do harm. Please state quite frankly what effect it has had on you, by putting a X against the statement (i) if you think it has increased your worry and that such lectures should not be given; or against (ii) if it has helped you and you think more such lectures should be given. If you are doubtful put a ? instead of a X.

"(i) It has increased my worry and such lectures should not be given.....

"(ii) It has relieved my mind and is helpful. More such lectures should be given....."

Of 5,740 votes 99.1% were in favour, 0.2% against, 0.7% put a ?

It has been argued that it is only the converted that attend these lectures. That is not true. These voluntary organisations such as the Women's Institutes, Townswomen's Guilds, etc., members come to the monthly meetings as a routine, and I don't think ever less than 50% of the members turn up. On one occasion, by mistake, I was billed to talk about 'birds'. When the true nature of the lecture was announced no one left the hall and the votes in favour were 100%. It has been argued that although it is easy enough to interest the audience at the time, later there is a reaction. This is difficult to prove or disprove. Recently I sent round a letter with a return postcard to 50 Institutes which had heard lectures given in 1956 and in the early

months of 1957. In this letter I said, "If after the passage of time your Institute thinks the lecture has done harm it will be your duty to let me know. If the opinion is against it please do not hesitate to say so. I shall not feel hurt". The results to date are as follows:—

50 enquiries sent out, 43 answered, every institute being convinced that these lectures were of value, and many of the remarks were most encouraging and a source of satisfaction, which makes the long and dreary hours of motoring in the dark seem well worth while.

Wakefield, who is running the Manchester Cancer Education Campaign, wrote round to all the G.P's in his area, and all agreed that there has been no increase in the number of patients attending their surgeries who had nothing wrong with them.

Another argument used by my opponents is that there are no statistics to prove the value of Cancer Education in saving life. That is true in this country because there has been such a small amount of Cancer Education, but there are some very suggestive figures from other countries. Sometimes it is said that a comparison between the five-year survival rate of those who were treated within six months of noticing symptoms is much the same as those who waited a year or more. The following figures for Cancer of the Cervix from Manchester are sometimes quoted on this point.

Duration in months (i.e., after the symptoms were noticed): 0—3, 4—6, 7—12, 13—24, 24+.

Five-year survival rate: 44%, 39%, 41%, 29%, 44%.

This, of course, is an absolute fallacy, the comparison being between two entirely different types of growth. In the first six months are the quickly growing, early disseminating, very malignant growths, in the second six months are only the slow-growing, slow disseminating tumours. A selection by death.

In spite of this difference in the type of growth, the figures published by Smithers for Cancer of the Breast (B.J. of Radiology, Supplement No. 4) show the value of early diagnosis, the rise in the survival rate does not recover until after 18 months' delay.

Delay in Months	No. of Patients	5-Yr. absolute survival rate
Under 6	364	43%
Between 6—12	173	28%
Between 12—18	98	26%
Between 18—24	34	41%
Between 24—30	53	26%
Over 30	75	33%

To obtain a true statistical evaluation of Cancer Education it is necessary to collect certain figures (A) the delay in visiting the doctor for certain symptoms whatever the cause, but which of course include cancer, such as painless lump in breast, irregular vaginal bleeding, etc., and (B) the number of early stage cases treated in the hospitals. If the delay goes down and the number of early stage cases goes up that would be proof of the value of Cancer Education, as these two factors can only be affected by knowledge. If

the five-year survival is used as a "yard stick", this may be influenced by better treatment and not by the education. Mortality figures are still more likely to be influenced by other factors, especially with an ageing population.

To conclude, it is my opinion that general practice should be considered a very important speciality, with a special training. The importance of understanding the patient's outlook, especially concerning cancer, and "suffering fools gladly" should be emphasised in the training of students.

The Family Doctor should have better Post-graduate training in Cancer Diagnosis and greater facilities for making a preliminary diagnosis.

"Knowledge is the antidote to Fear."

—Emerson.

PERIODIC MEDICAL OVERHAUL OF EXECUTIVES

by V. C. MEDVEI

Recently, the question of Periodic Medical Overhaul of Executives has again been in the news. Correspondents in *The Times* discussed its "experimental" application at the B.C.C. The physician who writes on "The way to Health" in the *Sunday Times* said (on the 9th of March) "... whereas all argument appears to be for them, I do not know of any doctor who has a routine check-up, and I have never heard of insurance companies reducing their premiums to those who have them." A lighter side of the question was ventilated in the correspondence columns of "The Times" of the 1st March, where a Mrs. Delgado wrote: "Nobody has suggested that the housewife should have a periodical health check."

"It may be because she is so fully occupied looking after the busy executive's meals in such a way that his duodenal ulcer is kept under control that she has very little

time to have one of her own—let alone any other occupational complaints. The busy executive, she is told, should delegate his duties and confine his work to office hours." "Both are admirable habits which the housewife might—on occasions—like an opportunity of acquiring."

Finally Cedric Carne in the doctor's column ("All in a doctor's day") of *The Sunday Express* of the 5th January, summed up his opinion by saying: "Basically, I don't believe in regular check-ups. People should go regularly to the dentist, even though their teeth seem in good order. But unless a patient feels there is something wrong with him, he should just raise his hat when he sees his doctor and say "Good morning" After all, do those very famous people like Eisenhower avoid illnesses because they have frequent check-ups? On the contrary, many who think of their

bodies as a sort of super-motor-car that needs a regular overhaul seem to become all the more illness prone."

The idea of regular check-ups is, of course, not new. For example, General Motors Ltd. have used the method in the United States for a number of years, and, more recently, also in England. The scheme is voluntary, and encourages every executive with an income of over a thousand pounds per annum to have a complete medical examination by a nominated physician once a year. If considered necessary, radiological and other laboratory examinations can be undertaken and the results are strictly confidential between the examining physician and the executive or the executive's private doctor, should it be considered desirable to inform the latter. The firm itself merely arranges for the examination and pays the necessary fees from a central office. A report on the result of the examination is sent to the person concerned, but no report whatever is given to the Company. If the report contains advice in regard to treatment or action to be taken, it is entirely for the executive to decide whether or not he is going to accept the advice. In the United States a similar scheme has been in operation for some time, but on a far more elaborate scale. There, apparently, the people participating in the scheme enter a Clinical Centre for a whole day and X-ray and other examinations are carried out as a matter of routine.

L'Etang discussed in an excellent paper "*The Health of Statesmen and Affairs of Nations*", the disadvantages which may have occurred in World affairs when Woodrow Wilson, Bonar Law, F. D. Roosevelt, Hopkins and Forrestal, Macdonald, Baldwin and Chamberlain, Bevin, Cripps and Keynes were stricken with illness and carried on handling their nations' policies. Quoting this paper, Chapman Pincher demanded in the *Daily Express* that a medical Board should be set up, to decide whether a statesman is fit for his duties and when he should be removed from office in case of ill health. The position is, however, not so simple as may appear at first glance.

Valuable as a scheme of periodic medical overhaul may be, if it is carried out automatically it may have several drawbacks. There are people to whom it may give a

sense of false security. It is known that in some cases of impending disaster of the coronary blood vessels of the heart, no clinical symptoms may be present and even examination by means of an electrocardiogram may not show up any obvious changes up to 24 hours before a severe attack occurs. I recollect a very important man in his late forties who had an expert overhaul before going to Switzerland on a holiday. Everything was found to be normal, yet he was laid up with coronary thrombosis on the night after his arrival without having indulged in any physical activities. On the other hand regular medical examinations may cause anxiety in some people. Only recently I had to see a gentleman who has to spend a great deal of his life overseas in an important position. A few years ago while he had a bout of indigestion (he is in his mid-forties) a medical man overseas, whom he had consulted, insisted among other investigations on an electrocardiogram. Happily, no evidence of major organic disease was found but ever since our patient has become heart conscious, insists on repeated electrocardiograms every four to six months (fortunately at his own expense!). He is a keen sportsman but whenever he is out of breath nowadays during his sporting activities he goes to see the nearest doctor to find out if he hasn't got angina of effort. Many of my colleagues have confirmed to me that automatic examinations of people over a certain age are often dreaded by the candidate concerned. There is fear that they may be told that something is wrong with them and the anxiety of a premature end of their career is constantly before their eyes. The voluntary nature of the examination does not always help. Although many people are afraid to go, they develop a guilt complex if they do not volunteer to undergo the periodic examination which has been arranged for them, and even politicians of great standing and personality would dread examination by an important medical board headed by people of the standing of the late Lord Horder or Dawson of Penn as has been suggested.

Besides, if such an idea is carried to its extreme conclusion, I doubt if Nelson would have been allowed to carry on as an Admiral in charge of the Fleet after losing an eye and an arm, and Trafalgar would not have been fought. Whole books have been

written on the health of Henry VIII and Elizabeth I (Chamberlin) according to which there were many periods in the lives of these monarchs when their health was below par. Who would have thought that crippled Talleyrand would outlive the giant Mirabeau by so many decades and be an efficient statesman beyond the age of 80. Lord Beaverbrook was known to be an asthmatic long before he entered the Government during the second world war and Roosevelt was paralysed years before he became President and was quite able to carry out his duties until his health eventually broke down in 1942 or 1943.

In deciding the real value of a medical examination a great deal will depend on the examining physician, whether he knows the background, the capacity, the responsibilities, and the tasks of his patient who has the confidence of the patient and who is able to guide him discreetly and successfully. For that reason great personalities in history preferred personal medical attendants who were at the same time their friends. This has always been accepted in the case of Royalty but in modern times Churchill's friendship with Lord Moran proved a very successful arrangement whereas Hitler's tendency to vacillate and surround himself more and more with cranks of doubtful standing and qualifications proved disastrous to him.

The practical application of these remarks is that it is important to have good medical advice from an efficient physician who also knows the work of the executive and is familiar with the whole background of his patient. He will readily be able to suggest the right line of medical examination should this become necessary and generally detect when something is amiss long before it is apparent.

It should also be remembered that an annual examination, even if carried out in form of a combined clinical, laboratory, and radiological investigation and if the results are put before a single medical consultant or a board of consultants they will not give

those medical experts a true picture of the possible stress to which he may be subject at home or at work, nor of his ability to respond to stress in the past or at the time of the investigation. It would, in my opinion, be a much better arrangement if the doctor who knows the patient well, would have a chance to compare the stress to which the patient is exposed at the time of the examination and his ability to stand up to them, with the same factors, one or several years before.

I have been working out such a "stress and stress resistance formula" for the past few years which should be sufficiently simple to be applied by the patient's own medical attendant and friend, and have some practical value. By such means it may be possible for people who occupy positions of responsibility to get guidance as regards their physical and mental stamina and their ability to carry out their tasks in a satisfactory manner.

The actual method will be published elsewhere at a later date.

To sum up: Periodic medical examinations imposed by an employer, as it were, from above, carried out by medical men who are strangers to the patient, appear to me of doubtful value; if a man, on the other hand, accepts an offer of a free medical examination by a physician he knows well or in whom he has special confidence, this may mean that he needs reassurance and such an arrangement may prove beneficial.

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MEDICAL PRACTICE IN NEW ZEALAND

by J. F. COPPLESTONE

THE STRIFE that besets the National Health Service when seen from afar in two month old medical journals, appears to have something in it of comic opera and of tragedy. I emigrated to New Zealand two years ago and have since been employed by the Department of Health in industrial and preventive medicine, a job that has far wider ramifications than any similar appointment in the United Kingdom. However, I do not wish to indulge in personal reminiscence but I thought your readers might be interested to hear some of the details of another kind of Health Service, which has sometimes been commented on favourably in the medical press.

The New Zealand Health Service was one of the first of its kind in the world, having been established by the Social Security Act of 1938. There were a few teething troubles but medical benefits have now been in substantially the same form since 1941.

The general practitioner may choose to practice under one of two schemes:—

1. A capitation scheme: this is operated by only one doctor, and is to all intents and purposes defunct.
2. A "fee for service" scheme: a flat rate of up to 7/6d. is paid for every medical service provided whether in the doctor's surgery (or "rooms") or in the patient's home. This service is calculated to take up to half an hour and the doctor can claim extra if it takes longer. The doctor can also charge the patient what he wishes in excess: the average total fee charged is in the region of 10/6d. for a consultation and 15/- for a visit but this varies a lot with the doctor and the area.

The doctor may choose to operate this scheme in two different ways. He may enter the patient's name and address on a schedule when he provides the service and charge the patient the excess. Every few weeks he sends in the schedules to the Health Department

who pay for all the patients listed. Alternatively, the doctor may charge the patient the whole amount and give him a receipt which the patient brings to the Department and is refunded. This is a more cumbersome system administratively but is favoured by many doctors as they consider it does not endanger that ethereal concept, the doctor-patient relationship. As an aside, it is interesting that in most arguments about health services, it would appear that this relationship is founded fundamentally on the amount the patient has to pay the doctor. Skill and personality appear to play minor roles.

Drugs are supplied under Social Security according to a schedule which lists the names of the drugs and in some cases the conditions for which they may be supplied, without charge to the patient. Generally speaking, the Schedule includes nearly everything in the British Pharmacopoeia, British Pharmaceutical Codex and the British National Formulary (1957) but some of the more elegant preparations marketed under proprietary names are not included unless their price closely approximates the ordinary price of the same drug. If a doctor prescribes some of these, the patient has to pay the difference between the ordinary price and the proprietary price if the drug itself is scheduled. It follows that doctors have to know somewhat more about pharmacology than trade names. Practitioners themselves may order a wide variety of drugs for emergency use as a charge on the Fund.

The public hospitals provide a range of in- and out-patient services similar to those in the United Kingdom and these services are without charge to the patient. Hospital Boards, which may run one or more hospitals within a given territory, are elected bodies but since last year all finance is provided by the central government.

There are a number of private hospitals and a patient in these can obtain a refund of part of what he has had to pay. This is based roughly on what it would have cost for the patient to fill a bed in a public hospital and

the rates vary according to the type of private hospital—medical, surgical or maternity. All private hospitals have to be licensed and are regularly inspected by professional staff of the Health Department. As a result they generally achieve a high standard of efficiency and staffing.

Maternity benefits are provided separately. In New Zealand, hospitalisation is practically 100 per cent, even if it means a 40-mile trip to hospital over indifferent roads, and most deliveries are done by general practitioners or specialists. Nurses train chiefly as maternity nurses and the number of midwives is relatively small. A general practitioner who looks after a patient before and after delivery and performs the actual delivery receives eight guineas.

This is necessarily a sketchy outline of the medical part of the Social Security Service. An important difference from National Health Service is in the central control of the Scheme. The profession is represented by the British Medical Association and deals directly with the senior officers of the Department, all of whom are qualified and many of whom have been in practice themselves. Thus doctor deals with doctor and the administration only is carried out by clerical civil servants. On a local level the Medical Officer of Health administers the scheme. This is an advantage that is not altogether appreciated by the profession in this country.

There is no restriction on the buying and selling of practices or on the setting up of new practices. The remoter areas, where no doctor could live economically in practice, but are far from other medical aid, are served by salaried doctors. These include men who, in return for a bursary during their training, give the Department the right to appoint them where it will for three years. They spend the first year in a hospital, but may then, for a period, be sent to one of these "special areas".

Needless to say, the profession are not united in approbation or disapproval of

Social Security but most of those who practised before the Scheme started are well enough content. The fact remains that, apart from farmers possibly in these days of high wool prices, doctors have the highest gross average income in the country. This is reflected in the facilities provided since practically every general practitioner has a nurse in his rooms, and the standard of practice generally is high. Its limitations are basically due to the common factor in many problems in this country—a population of just over two million in an area slightly larger than the United Kingdom.

Bart's men are well represented in the Health Department, there being three of us among the twenty Medical Officers of Health and their deputies. However, lest there should be a sudden efflux depriving the "Old Country" of the cream of its profession, I should, perhaps, end by a word of warning. The Otago Medical School in Dunedin turns out about ninety new doctors a year and the larger towns are now approaching saturation point. There is some scope for general practice in country areas but capital would be advisable to tide over the settling-in period. Alternatively, if more capital is available a practice could be purchased. There are often vacancies for assistants and long-term locums while the principal refreshes himself by a trip to the United Kingdom. There are plenty of English doctors out here and degrees and diplomas are reciprocal. I would advise anyone thinking of emigrating: if you appreciate hard work and a rather simpler standard of living in which the family plays a much larger part, and if you have an adaptable and versatile wife, then this is a good country.

Acknowledgement

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UNUSUAL CASES IN GENERAL PRACTICE

by L. S. CASTLEDEN

IN THESE days of rapid travel, the appearance of tropical illnesses in English practice is not rare, the following cases show:—

Case 1

A commercial air-line pilot, aged 32 years. He said he "had a dose of 'flu'". He had been flying a route to the west coast of Africa and he had not availed himself of anti-malarial suppressives. Four days before he had a "chill" in the evening with aching in the back and limbs. He had a cough and some sputum.

On examination his temperature was 100.2°F.; pulse rate 90 per minute; respiration rate 22 per minute. There were a few moist sounds in his chest, otherwise no abnormalities could be found.

He was considered to be a case of influenza with bronchitis and he was given "sulphamezathine". After 24 hours' treatment the fever was 102°F. and there were profuse sweats and rigors. The chest condition did not alter. Two blood smears were taken and stained with Leishman's Stain. A surprisingly high number of benign tertian parasites were seen—about two-six affected corpuscles in each field. He was transferred to hospital where the diagnosis of malaria was confirmed. The chest X-ray showed no pneumonia. He made rapid recovery when treated with paludrine.

Case 2

I received an urgent call to go to a village some six miles away. Incidentally there had been a heavy fall of snow the night before, and all the lanes were impassable to motor cars. Accordingly, the children's pony was pressed into service. The patient was found to be a man of 44 years who was on leave from Hong-Kong, where apart from a period as a Japanese P.O.W. he had worked all his life. He had felt unwell while travelling and had dosed himself for malaria. In spite of this his temperature had climbed steadily.

He had developed a pain in his right upper abdomen and back and also an aching in the tip of his right shoulder. There was no diarrhoea or vomiting and no cough.

On examination his temperature was 104°F., pulse rate was 100 per minute and respiration rate 20 per minute. His skin was hot and dry. He was sensible and there was no "Typhoid state" or dehydration. The most remarkable finding was that the liver dullness on the right side was a full hand's breadth higher than usual. The liver could also be felt per abdomen and was very tender. The trachea and apex beat were not displaced but no breath sounds could be heard at the right base. Nor were there any added pulmonary sounds. He was straightway suspected of having an amoebic abscess and when the snow melted was investigated at the local hospital. The X-rays showed that the diaphragm was indeed pushed upwards on the right side by the liver. Amoebic cysts were present in the stools.

He was thereupon moved at once to the London School of Tropical Medicine. His liver enlargement did not respond to emetine as rapidly as was hoped but after needling and the removal of quantities of "anchovy" pus he made a good recovery, and returned to Hong-Kong.

Case 3

A little girl of three years had returned from Nigeria with her parents. She had been given a perfunctory dose of "camoquin" for suspected malaria after arrival. However, she had a straightforward attack of acute tonsillitis and was thereafter rather "pecky". It was noticed that she was less well every fourth day. A temperature chart was then taken and it was found that she ran a fever up to 104°F. every fourth night. Clinically, apart from slightly enlarged tonsillar glands, no abnormality was found. The blood smear was never obtained at the right time but she was regarded as a clinical case

of malaria. Since a more sustained course of "Camoquin" she has had no further trouble.

Case 4

The sister of the last patient is aged eight years. Amongst other places the family has lived in Calabar district. In fact the father has been clinically diagnosed as suffering from filariasis. Although this little girl returned from Nigeria some ten months previously, she was perfectly well until she developed fugitive swellings which lasted about four days.

When examined, there was no fever. The child looked rather pale but was active and happy. There were two swellings present. On the back of the right hand there was a soft swelling $2\frac{1}{2}$ in. x 1 in. It was sufficiently large to make it difficult for her to write, but was not unduly tender. The margin of the swelling was more pink than the central area. It was warm to touch but not as hot as an abscess would be. One had the definite impression that this swelling resembled more the reaction to an insect bite than a cellulitis.

The second swelling was on the right thigh. It had been present $2\frac{1}{2}$ days. It also was subcutaneous. The colour was darker and the swelling less marked, the area of induration being 1 in. x $\frac{3}{4}$ in. This lesion was

more like a fading lesion of erythema nodosa.

She was referred to the Hospital for Tropical Diseases. The following investigations were done: (1) The filarial skin test, using an antigen prepared from *D immitis*, the filarial worm of dogs, was positive; (2) The filarial complement fixation test was strongly positive; (3) Blood examinations failed to show any microfilariae of *loa loa*; apparently the production of embryo worms in any quantity does not occur till about two years after infection—even though adult worms may be already roaming about the body.

The patient was treated with "Banocide" on the strength of these results and no more swellings have appeared.

These cases have a special interest for me because I was fortunate enough to attend a course in tropical diseases during the war. In any case they do show how General Practice even in rural England covers the *whole* field of medicine. Rarities are admittedly the plums in the pudding. But it should be remembered by those setting out into General Practice that in no other medical career will they meet so much variety. Whether the practitioner himself enjoys the job entirely depends on his attitude. He is most likely to be happy if he keeps his interests, both medical and otherwise, as wide as possible.

A NEW ZEALAND VISIT

by J. WATSON

IT WAS a great honour to be selected to represent the Air Training Corps on this reciprocal visit to New Zealand, not only for myself, but for my parents, my Squadron and my school. The time between the news of my selection and the day of departure soon passed. I was absorbed by the vast

machinery of the Royal Air Force and really felt that the greatest adventure of my life had started.

My colleague D. A. Noon, now at Cranwell, and I left a wet and cloudy Lyneham in a Hastings of Transport Command and headed for the staging post at

Idris via London, Paris and Marseilles. Next to Cyprus, that barren rock planted by the hand of nature just one hundred and fifty miles west of Palestine. Owing to the fact that we were "fortunate" enough to develop engine trouble we were able to visit Nicosia the capital. Unfortunately this old Crusader's fortress has lost all the atmosphere that a town with its history and background should have "Coca-cola" signs flash across the sky, while juke-boxes bellow forth the latest hit tunes, and fast American cars speed down the narrow streets. Of course the architectural beauty was clothed in darkness so we finished off the evening by seeing a second rate American film with sub-titles in Greek, French and Arabic.

From Cyprus we flew on to Habbaniya in the middle of Iraq, fifty miles from Baghdad. This oasis revealed to us exactly what man and machine can do with the desert. They have turned a wilderness into a town, with shops, cinema, swimming pools and even a golf course. The wonder of the place is enhanced by the tree lined roads radiating from the central point, the church.

Murepar in Parkistan was the next stop, then on down the coast of India to Ceylon and Negombo, some twenty miles from Colombo. In the evening we were invited by two Pilot Officers to share a taxi into Colombo. On the journey into town we passed through native villages, seeing wealth in the temples that line the road, and poverty and squalor in the streets as children sat or played in the gutter. It seemed strange to see how the modern world has blended with the old: Neon lights proclaiming "Mobilgas gasoline station", illuminated chromium plated facades, while next door the village barber plied his trade by the light of a tallow candle. Colombo with its wide streets proved to be a town with a narrow selection of goods, its redwood and ebony elephants, its diamonds and sapphires and of course, the restaurants selling food ranging from Yorkshire pudding to birds nest soup.

There followed eight hours' flying across the Bay of Bengal en route for Singapore. Despite the adverse weather our navigator brought us on to the coast of Malaya at the exact spot marked on his chart.

The transit hotel at Changi Creek was to prove to be a place of pleasant memories

and we were truly sorry to leave Malaya but we had to be in New Zealand on time. En route in the New Zealand Hastings for Darwin we missed the job of quartermaster, no longer were we able to "go up front" with the crew, but we had the consolation that in approximately two days we would be in New Zealand, but first we had to travel across the boundless wastes of Australia from Darwin to Brisbane and then on. Soon through a gap in the clouds I had my first glimpse of New Zealand, the thin white line of surf breaking on the Western beaches. At exactly 16.00 hours (local time), we landed at Whinupia (pronounced Fu-nu-a-pie).

The few ideas I had about New Zealand were dispelled as we drove from the Airport to Auckland. I had thought it to be a flat, barren country, but instead I saw green fields, pine trees, peach orchards, vineyards and hills. In the evening we were driven to a hot spring for a swim, pausing to admire a New Zealand sunset.

During the ten days in Auckland, we were taken by our host, the New Zealand Air Training Corps, to various places of interest. We fitted in visits to Auckland's famous Phia beach; we broadcast on the commercial radio, advertising the network; we went round an aircraft factory and the War Memorial with its Maori Village. An Air Pageant was another highlight of our stay, owing to the absence of snow Father Christmas arrived by parachute from "Reindeer land" to distribute sweets to the children.

We reluctantly said good-bye to Auckland and headed South East to Gisborne through the Devon-like country of Central North Island. Gisborne is famed throughout New Zealand for its hospitality, and its people certainly made us welcome, with flying at the Aero Club and parties in our honour, coupled with trips out.

On Christmas Eve we were able to see what effect the absence of snow has upon these—dare I use the word?—Colonials. They close the main street and the entire population wearing paper hats congregates to march up and down singing carols, throwing fireworks and streamers. In fact we thoroughly enjoyed this novel way of spending Christmas Eve "While gentlemen in England, then abed should think themselves accursed they were not there," as they thought only of warm fires and holly.

Christmas Day was perhaps a little sad thirteen thousand miles from home, but my host, a farmer, made an excellent job of cheering me up. I was accepted as one of the family and really made to feel at home. My stomach capacity was tested at dinner time as with sixteen friends and relations we sat down to a feast of five chickens, one whole sheep, one leg of ham, various vegetables and of course Christmas pudding.

Our next stop was "Windy Wellington" as the citizens call it, with beautiful blue skies and gusts of wind up to ninety miles an hour. In Wellington we had our only official engagement and that was a visit to the home of the A.O.C., R.N.Z.A.F., Air Vice Marshal Merton, at Lowry Bay. On again across the Cook Straits to the mainland and Nelson. Unfortunately we were there only for one whole day, but we made good use of the surf that pounds the pine tree lined beach. On New Year's Eve the town went mad. We all went to a late showing at a cinema, then at 11.50 amid rockets, bangers, streamers and paper hats we spent the rest of 1954 listening to a pipe band playing Auld Lang Syne. Then on to a party and home at three in the morning.

We said goodbye to Nelson and journeyed on to Christchurch through the Lewis Pass. Christchurch was very English and as usual our hosts were extremely kind. We were completely free to do as we pleased, and spent a wonderful two days swimming from Brighton beach and exploring the town.

Our next stop was Dunedin, and I was determined to pay a visit to the Medical School. Presenting myself at the Inquiry Desk and asking if I could be shown round I was told that it was impossible as everyone was on holiday. Not to be outdone I mentioned that I was hoping to commence my studies at Bart's in the following October. These were the pass words, and soon I was being shown over the School.

From my guide I learn a little of the history of the School and the course of study which the students follow.

The school was opened in 1875, the course being of two years duration. In 1883 the council of the University of Otago took steps to improve and extend the medical curriculum and the Dunedin Hospital was made available for the use of the school,

with the result that in 1886 a full course of instruction in medicine was made available.

Since then, the school has extended rapidly. In the early part of the century the Physiology Dept. was severed from the Anatomy Dept. In 1911 a Chair of Bacteriology was established and three years later that of Pathology. Then in 1919 the council appointed a Professor of Clinical Medicine and Therapeutics, and a Professor of Systematic Medicine. This was followed in 1931 by the appointment of a Professor of Midwifery and Gynaecology, and in 1939 a full time Professor of Medicine was appointed. 1949 saw the division of the Physiology and Bio-chemistry depts. thus establishing a Chair of Bio-chemistry. The latest development is that the Chair of Bacteriology has been replaced by the Chairs of Micro-biology and Preventative and Social Medicine.

The candidates read for M.B. Ch.B. and entry is by means of a competitive examination. Those wishing to study Medicine take English, a foreign language, Mathematics, Chemistry and Physics for their school leaving certificate. The first 120 are admitted to the course for the Medical Intermediate. This is the equivalent of first M.B. Those who pass go on for the course for the First Professional Examination consisting of Anatomy, Bio-chemistry and Physiology. They then go on to the Second Professional Examination which includes Pathology, Medical Micro-biology, Pharmacology and Therapeutics. This in turn is followed by the Third Professional Examination which is divided into two parts. Part 1 is taken at the end of the fourth year on Preventative Medicine and Medical Jurisprudence. Finally, they are examined on Surgery (Clinical and Operative), Medicine (including Paediatrics), Obstetrics and Gynaecology. Now follows an internship of a year, six months surgical and six months medical, after which he is allowed to go into Practice.

We left Dunedin in boiling sunshine for Invercargill. We visited a Slaughter house and saw sheep being killed for consumption in Great Britain; then on to the Southernmost tip of New Zealand at Bluff, followed by a visit to a Wireless Station which can, if the occasion arises, contact shipping in the Thames; then on to one of the highlights of the tour, a flight through the fiordland of the South.

On again another one hundred and sixty miles to Auckland, and our tour was nearly over. But before we left we were to go to an N.C.O. Camp at Whinuappia, to eat, live and sleep with New Zealand Cadets, sharing their working and leisure hours. They were a great crowd and we really had fun especially when an American singer arrived at the airport and "The English Cadets" were called upon to organise a barrier to stop five thousand screaming female fans from mobbing him.

January 19th dawned grey as if in line with our thoughts, for we were sorry to be leaving New Zealand, our home for the last five weeks. We said our goodbyes, and took our seats, the quartermaster closed the

door, the engines burst into life and with a roar our Hastings moved forward: we were going home.

We flew across the Tasman Sea to Brisbane, then on again to Singapore only stopping at Darwin and Jakarta to refuel; then to Car Nicabar and Negombo; then on up to Marepar and so to Bahrain and Habbainya. Up early for the flight to Malta via Nicosia across the snow clad desert of Palestine. We landed at Malta, that heroic Island with its magnificent war record, and we had time to visit Valetta with the steep narrow streets of the old town cut off by the now empty moat from the new partly rebuilt area. On again over France to England and Lynchem. A journey of over twenty-eight thousand miles was over.

SPORTS NEWS

VIEWPOINT

Now is the time of year when Winter games come almost apologetically to a close, and Summer ones start to come out of hibernation. There is a relative dearth of obvious activity and the time when some senior students leave the ranks for the house, or elsewhere! Lastly, now is the time when new members of clubs can best make their presence felt. No club can do without them, but it is early in the season that they can best attract attention, and thus establish themselves in the various teams.

The date of Sportsday is in this month's sports calendar. Is it a pious hope that more people will endeavour to be present this year? Besides being one of the social occasions of the year, it involves the Athletics club in a great amount of work, and a heavy financial risk. The cost is well over £100, and rising, and a few pounds extra on programmes and teas can tip the balance.

SPORTS CALENDAR

Wed, Apr. 2	Golf Club Spring Meeting at Sundridge Park.
Wed. " 9	Golf v. Guy's at Croham Hurst.
Wed. " 16	Golf v. Westminster at South Herts.
Wed. " 23	Golf v. Middlesex at Hendon.
Sat. " 26	Tennis v. London House (H).
Sun. " 27	Cricket v. London House (H) 2.30 start.
Wed. " 30	Tennis v. School of Pharmacy (H).
Th. May 1	Golf. Beveridge cup meeting at Sunningdale.
Sat. " 3	Tennis v. Westminster (H). Cricket v. U.C.H. (A) start 11.30.
Sun. " 4	Cricket v. Putney (H) start 11.30.
Sat. " 10	Tennis v. Charing Cross and Royal Dental Hospitals (A). Cricket v. R.A.M.C. Crookham (H) start 2.30.
Sun. " 11	Cricket v. Hampstead (A) start 11.30.
Wed. " 14	Athletics v. Westminster Bank (A) start 6 p.m. Golf. Staff Match at Denham. Tennis v. Guy's (cup match) (A).
Sat. " 17	Tennis. Cambridge tour. Emmanuel. Cricket v. Balliol College, Oxford (A) start 11.30.

Sun. .. 18	Tennis. Cambridge Tour (cont.) Trinity. Cricket v. Romany (H) start 11.30.
Wed. .. 21	Athletics v. Guy's and 'The London (H) start 2.30. Tennis v. K.C.H. (A).
Sat. .. 24	Cricket v. Queen's College, Cambridge (H) start 11.30.
Sun. .. 25	Golf v. Mr. Hankey's Team at Tandridge.
Wed. .. 28	Golf v. King's College at Sundridge Park. Athletics v. St. Thomas's and Middlesex Hospital (A).
Sat. .. 31	Tennis v. St. Mary's (H).

WOMEN'S HOCKEY

CUP MATCH

The final of the Women's Inter-Hospital Hockey Cup competition was played on Saturday, March 8th, on the Middlesex Sports ground at Chislehurst, between the Royal Free Hospital and Bart's.

The Bart's women have won this trophy for the past four years and could it be won for the fifth successive time was the thought in the minds of the Bart's spectators. The spectators were treated to a thrilling game and included Mr. J. B. Hume, Mr. Nash, Dr. Lehman, Dr. Blunt and Prof. Wormal.

The Royal Free Hospital had previously beaten Bart's this season and at the beginning of the game it seemed as if the trophy would change hands as the Royal Free launched many attacks on the Bart's goal. The Royal Free played with more assurance and were more purposeful than the Bart's team and there was little to make the Bart's spectators confident of victory. The Bart's goal proved impervious to the Royal Free attacks and after about ten minutes of the first half the Bart's players became more confident and previous isolated attacks on the Royal Free goal gave way to sustained periods of attack. The game was developing into a ding-dong battle with the Bart's defence and forwards combining well. Miss Barnard and Miss Knight were prominent in the defence, covering well and distributing the ball to their forwards where Miss Hartley's stick work and the speed and energy of the wingers of J. Swallow and J. Arnold did much to unsettle the Royal Free defence.

After some exciting play, both teams were now playing well, J. Arnold had a good run up the right wing followed by a centre from which Y. Chambers scored. Soon afterwards the Royal Free equalised. Score 1-1.

The second half started with the score 1-1. The game was exciting to watch and Mr. Hume, Mr. Nash and Prof. Wormal were frequently seen

walking up and down the touchline encouraging the Bart's team to greater efforts.

The second Bart's goal was scored by J. Arnold from a centre by J. Swallow. The Royal Free soon equalised from a break away and the score stood at 2-2 at full time.

Two ten minute periods of extra time were played. The Royal Free scored first. This seemed to stir the Bart's team to greater efforts and soon their labours brought the equaliser. J. Hartley scored a good goal from a pass from J. Chambers. The game at this stage was interrupted by Miss Chambers contracting a severe attack of cramp, after some expert attention from the Dean Miss Chambers was able to carry on. A couple of minutes from the end the final goal was scored by Y. Swallow to make it 4-3 and a Bart's victory.

Mr. Nash presented the shield to the Bart's captain, J. Hartley, and congratulated the team on a splendid performance in winning the shield for the fifth successive year. Both teams should be congratulated for playing a game of a high standard and one so exciting to watch.

Team :

I. Tomkin, G. Barraclough, J. Tuft, E. Knight, B. Barnard, Y. Hall, J. Arnold, J. Hartley, J. Chambers, S. James, J. Swallow.

RUGGER

1st XV v. Harlequins Wanderers. Away on March 22nd. Won 9-0.

On a sunny but very cold afternoon at Teddington, the 1st XV gained a highly satisfying and in no way undeserved victory over Harlequins Wanderers, who three weeks previously, had beaten St. Thomas's, this year's Cup Winners, by over twenty points.

Playing on a hard surface for the first time for several months, the Hospital completely outplayed their more illustrious opponents forward in the second half, after an even first half. Kicking off against a stiff breeze, Bart's were on the attack at once. Phillips was soon prominent, when he successfully followed up one of Bamford's astute diagonal punts, and he only just failed to score. However, after gathering another of Bamford's kicks, he beat his man and the full-back to score a fine try in the corner. The remainder of the half was fairly even, with Bart's pack holding their heavier opponents in the tight. They were also faster on to the loose ball, when the Harlequins backs were harassed into mistakes by a rampant back row of Mackenzie, Boladz and Randle.

In the second half, Bart's again attacked early, and Phillips and Halls were often prominent in raids on the Harlequins' line. However, the opposition were still winning the ball in the line-outs, and set up strong counter attacks which only floundered on a fine defensive. In this Bamford and Mackenzie were very prominent, and it was during such work that Bamford received a nasty blow on his head that necessitated his playing on the wing for a short spell. However, controlling the loose play admirably, Bart's forwards scored a try half way out. Mackenzie was up to touch

down after a forward rush from the Harlequins twenty-five. Further attacks in which Davies was prominent resulted in an excellent try in the closing minutes. Mackenzie was again in the right place to score, with a dash from thirty yards out after a good movement by the Bart's three-quarters. All three of Stevens' kicks only just failed to add the necessary goal points.

This indeed was a most commendable display, and it proves that there is ample skill and spirit still well to the fore in the side before the Welsh Tour at Easter.

Team :

M. Britz ; R. M. Phillips (Capt.), J. Bamford, J. Stevens, G. J. Halls ; R. R. Davies, B. Richards ; J. L. C. Dobson, J. W. Hamilton, B. Lofts ; L. R. Thomas, C. C. H. Dale ; G. Randle, W. P. Boladz, J. C. Mackenzie.

1st XV v. Loughborough College. March 8th. Home. Won 11-3.

In a rousing vigorous game, the 1st XV gained an excellent win over Loughborough College whom we have not beaten apparently for twenty-three years and who had previously lost only one game this season. This success was due in the main to another fiery display by the forwards both in the tight and the loose and also to the backs accepting their opportunities when they arose. The final Bart's try was a real gem by R. R. Davies who engineered a brilliant dummy scissors with McMaster to bamboozle the opposition completely and for Davies to touch down under the posts for Stevens to convert. This put the final seal on a highly entertaining and fast display of open rugby in which the Hospital forwards easily kept up with their reputedly fitter opponents.

Kicking off into a stiff breeze, Loughborough launched a series of attacks which were thrown off quickly by Bart's who shortly took the lead through a neat 30 yard penalty by Stevens. Further raids by the Hospital with wingers Phillips and Halls often prominent tested the opposition defence severely but no score resulted. During the period, the back row of Mackenzie, Harries and Randle were continually harassing the opposing three-quarters into handling errors which several nearly resulted in scores for Bart's. Just before the interval, Stevens kicked another penalty from in front of the posts to give Bart's a well deserved lead of six points.

Immediately after the resumption, Loughborough repeatedly won the ball from line-outs where Thomas was badly missed. They threw everything into attack and scored an excellent try when their full-back as well as a loose forward joined in an orthodox move for them to score wide out, the conversion being missed. Further onslaughts on the Hospital line continued but the defence held and gradually Bart's won more of the ball from the tight and loose scrums again. Here, Hamilton was doing sterling work by repeatedly outstriking his opposite number and Boladz and Pennington were often seen in the thick of vigorous forward exchanges.

The game reached a fitting climax when Rees Davies scored in the closing minutes which crowned a highly satisfactory afternoon from the Bart's point of view.

Team :

M. Britz ; R. M. Phillips (Capt.), A. B. M. McMaster, J. Stevens, G. J. Halls ; R. R. Davies, B. Richards ; J. L. C. Dobson, J. W. Hamilton, B. Lofts, J. Pennington, W. P. Boladz, G. Randle, L. R. Thomas, J. C. Mackenzie.

1st XV v. Aldershot Services. Home. Lost 5-11. March 15th.

Taking the field without the services, through domestic and other reasons, of Mackenzie, Hamilton, Pennington and McMaster, the 1st XV lost to a strong Aldershot Services team by eleven points to five. Although they held their much heavier opponents until the last quarter of an hour and were in fact leading 5-3, Bart's in the end gave way forward and allowed the Services to score two easy tries, resulting from stupid mistakes.

Kicking off on a very sunny afternoon at Chislehurst, Bart's were soon attacking and it seemed at this stage that the more mobile Hospital pack would more than hold their own against the far heavier and more experienced Services eight. With Bamford and Rees Davies being prominent early on, Bart's did most of the attacking and a score soon came after quarter of an hour's play. Breaking left on the Services twenty-five, Davies missed out his inside centre and passed to Bamford who made an outside break for Halls to carry on and score an excellent try half way out for Stevens to convert with a good kick. Thereafter, play was more even with Smith making an able deputy to Hamilton and Thomas and Boladz ensuring a fair supply of the ball from the line-outs.

After the interval, Bart's continued to press hard for a time and several times only failed to score when the vital final pass was dropped. Gradually, the Services pack wore down their opposite numbers and after twenty minutes they kicked a good penalty from thirty-five yards. Towards the close, the Hospital pack became very demoralised and were beaten in all departments of the game. Stoutly though the backs defended, they could not prevent two tries being scored in the last ten minutes for the Services to run out seemingly comfortable winners.

Team :

M. Britz ; R. M. Phillips (Capt.), J. Bamford, J. Stevens, G. J. Halls ; R. R. Davies, B. Richards ; J. L. C. Dobson, P. Smith, B. Lofts, W. P. Boladz, C. C. H. Dale, R. P. Davies, L. R. Thomas, G. Randle.

MEN'S HOCKEY

1st XI v. Bandits. Sunday, March 2nd. Lost 2-5.

As always happens for a Sunday match, it was impossible to get out a full side and the result of the match was rather anticipated. It was, however, an enjoyable game against pleasant opponents and played on a hard dry ground.

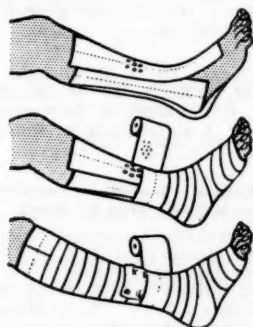
We started badly and it was not long before a muddled defence had allowed two half-hearted shots to dribble over the line. This inspired our forwards to greater efforts and, following an ex-



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tremely good run, Anderson scored with a perfect reverse-stick shot. The Bandits scored again just before half-time. The second half proved much more even, with both sides attacking equally. Gordon made many good saves in goal and Garrod and Debrates successfully broke up many attacks. Both sides scored again, our goal coming from a very powerful flick by Halls, who had relinquished the oval ball for the afternoon and proved a great success together with Charlton on the right wing. In the closing minutes the Bandits scored again after their inside forwards had torn open our defence.

Team:

A. J. Gordon; J. A. Garrod, M. Debrates; N. C. Roles, K. MacKenzie-Ross, C. J. M. O'Keefe; J. Bousfield, A. S. Anderson, D. N. C. Glover, C. A. C. Charlton, G. J. Halls.

1st XI v. Oxted. Away. Saturday, March 15th. Won 2-1.

This was the sort of match about which one likes to forget rather rapidly! It was a fine day and a pleasant drive down to Oxted but unfortunately the groundsmen had gone on strike and even a self-respecting cow might have hesitated before considering grazing upon the plot of land called a 'pitch'. I think most of the people playing agreed that our opponents were the most robust players we have played for some time. It is a difficult game to describe because it was hardly hockey — perhaps that is why we won . . .

The day was saved, however, by the President of the Club and Mrs. Jaynes, who opened their home in East Grinstead, and their bottles, to us and entertained us extremely well — as far as I remember! We are very grateful to them both for their kindness.

Team:

C. Craggs; Dr. J. B. Nichols, J. A. Garrod, C. J. M. O'Keefe, K. MacKenzie-Ross, D. S. Wright, J. Bousfield, A. S. Anderson, D. N. C. Glover, P. J. Kingsley, N. C. Roles.

Inter-Hospital 6-a-Side Competition. Sunday, March 23rd. Won by Bart's.

Beat: Guy's B.	4-0
St. George's	2-0
St. Thomas's	4-3
St. Mary's	1-0 (Semi-final)
Guy's A.	2-1 (Final)

This competition was played at Cobham on what was certainly one of the coldest days in recent months, with a bitter East wind blowing. I think this result came as a great surprise to everyone but a side with the speed and fitness which we mustered that afternoon deserved to win. Our tactics were extremely good, playing out to the two wings, Anderson and Drinkwater, who are both extremely fast and capable of beating anyone with speed and stickwork. Glover, at centre-forward proved a foreful player with plenty of dash and determination while Roles and Kingsley at half made a solid combination with MacKenzie-Ross at back. No one can be singled out for praise for everyone played extremely well and with great spirit.

When the final came, we had already played one more game than our opponents and yet we were still far fitter. Drinkwater it was who scored our winning goal in extra time — a fitting person to do so, having been chosen for the Final England Trial.

This was certainly an afternoon to remember and a wonderful way to end off a rather mediocre season. Great credit is due to our team.

K. MacKenzie-Ross; N. C. Roles, P. J. Kingsley; A. S. Anderson, D. N. C. Glover, P. Drinkwater.

BOOK REVIEWS

HISTOLOGY (3rd Edition) by Arthur Ham. Published Pitman's Medical Publishing Co. Price 80/-.

This is an excellent book though it contains far more information than is required by most medical students. This edition has been very extensively revised and special attention has been given to the rapid advance which has been made in the study of fine structure by electron microscopy. There is a preliminary account of the working principles of both optical and electron microscopes; unfortunately this does not discuss the question of numerical aperture and the diagram illustrating the path of rays through the two instruments has a fundamental error. Both light rays and the electron beam converge upon the specimen at an angle approximately equal to that taken up by the objective, whereas in the offending diagram these rays are shown as a parallel. There is an adequate explanation of the basic properties of light in the section dealing with phase contrast and interference microscopy, but the explanation of the instruments is not easy to follow and no diagrams are given.

These are only minor criticisms, and in the histological field the quality of the book is high. The account given of the fine structure of striated muscle does not include references to the latest work of the Huxleys and Hanson; the most recent electron micrographs published by these authors show the separate existence of actin and myosin filaments with a clarity which leaves no room for doubt.

F.J.A.

THE CHILD AND THE FAMILY by D. W. Winnicott, F.R.C.P., pp. 147. 12/6.

THE CHILD AND THE OUTSIDE WORLD by D. W. Winnicott, F.R.C.P., pp. 190. 163. Edited by Janet Hardenberg, M.B. Tavistock Publications Ltd. (1957).

Dr. Winnicott is a unique figure in British paediatrics. An old Bart's man and one-time

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The call for a second edition of this book, which appeared first under the title *Lectures on General Pathology*, has enabled the authors to revise its contents and add new chapters on thrombosis, metabolic changes following injury, atherosclerosis and tumours, thus enhancing its value by covering a wider field.

(1958) 84s. net.

RECENT TRENDS IN CHRONIC BRONCHITIS

Neville C. Oswald

The main purpose of this book is to bring together under one cover for the first time recent views upon the various facets of chronic bronchitis. Culled from their experiences with chronic bronchitis at the Brompton Hospital since 1950, the authors present their views on the diagnosis, prevention and treatment of this distressing and often killing disease.

(1958) 30s. net.

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editor of the *Journal* he has combined the practice of the paediatrics of sick children with the very detailed psycho-analytical treatment of the emotionally maladjusted and the psychotic. He is essentially a simple and humble-minded physician, full of wonder about the problems presented by his patients and therefore full of wonder about the normal development of the emotional pattern of his fellow beings. Were there any method of studying the psychology of the foetus, Dr. Winnicott would be working hard at it and carefully recording his observations. As it is he has plenty to say about babies, children and their family and social relationships. The lectures and papers published in these two books are aimed at the laity and this includes medical students, nurses and even consulting paediatricians when the detailed analysis of infant behaviour is in question. The reader quickly discerns some of the ingredients of the author's success. Not only is each person important, but each detail is important. Babies cry. He asks why do babies cry? And then he puts himself in the position of the crying baby and of the mother of the crying baby, with sympathy and rare insight, and if his premises are correct his logical conclusions are inescapable. And so he builds up his case and because his problem is broken down into its simplest elements, his explanation is simple, his advice straightforward and practical. And the reader is bound to agree that these details are important, and that if everyone concerned with child care from the neonatal nursery to the school, mother, father, midwife, health visitor, doctor, hospital nurse, nanny, school teacher, understood all that Dr. Winnicott teaches, the world would be less of a jungle for the developing child.

A. W. F.

CEREBRAL PALSY IN CHILDHOOD by G. E. Woods, with a foreword by Peter Henderson, Bristol: John Wright & Sons Ltd. (1957) pp.xi, 158. Fig s. 41. Price 27s. 6d.

Dr. Grace Woods has produced an excellent study of cerebral palsy as she has seen it in Bristol during a five year research. In this book her results are carefully set out and add to the sum of medical knowledge about this most difficult subject. In Bristol the number of cerebral palsied children reaching the age of 5 years is 1.90 per 1,000 live births. Cerebral palsy is not a unity but is a convenient label for cases of defective movement due to disease of the brain. The cases are therefore classified according to the movement defect, paraplegia, monoplegia and so on. There are then chapters on the types of movement defect, athetosis, ataxia and rigidity, on the sensory defects, and on the relationships of cerebral palsy with birth process factors and social groups. Epilepsy was found in 38 per cent. and assessment of educability was needed in them all. The author is to be congratulated on this factual statement about the clinical findings and the problems raised in the education of a group of 301 cerebral palsied children which can be read with profit and with real interest.

A. W. F.



WHAT'S THE USE

A famous mathematician once proposed a toast: "To the higher mathematics, and may they never be of any damned use to anybody." Another mathematician said more recently that the subject had no practical value—that it could not be used directly to accentuate the inequalities of human wealth, nor to promote the destruction of human life. We do not know whether the early biochemists held such a pleasantly detached view of their researches, or whether, if anyone said, "What's the use?", they would hopefully reply, like Faraday, "What use is a newborn baby?"

Whether their words were modest or not, useful value has, in fact, come from their work. Spectacularly so in the matter of the functions of vitamins. Take vitamin B₁—in other words, thiamine. It has now been established that thiamine is essential for the oxidation of pyruvate. When thiamine is lacking, pyruvate accumulates. This can cause very unpleasant, even serious symptoms. Various neuropathies (for example, tobacco-alcohol amblyopia with its alarming blindness) are associated with thiamine deficiency. Even today in diet-conscious Britain, minor degrees of thiamine deficiency are by no means uncommon. Those who eat much carbohydrate need extra thiamine, as well as riboflavin and pyridoxine—indeed all the B-complex vitamins; and so do children when they are growing fast, and lactating and pregnant women, and girls slimming on slender diets. That is where Bemax is so useful. Being pure stabilized wheat germ, it contains all the B-complex vitamins, and is rich in iron and protein. You just sprinkle it on your food; Bemax goes well with cereals, curries, and a host of other dishes.

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